

AFFIDAVIT OF COMPLETION OF AIT PROGRAM

Health Professions Bureau
Indiana State Board of Health Facility Administrators
402 West Washington Street, Room W066
Indianapolis, Indiana 46204
317-234-2051
<http://www.in.gov/hpb/boards/isbhfa>

I, _____, do solemnly swear or affirm under the penalties of
(Name of Preceptor)
perjury, that I have:

1. Supervised the A.I.T program of _____ for _____ months;
2. Familiarized the A.I.T with my duties and responsibilities;
3. Arranged for the A.I.T to be assigned responsibilities in and have an opportunity to observe each department;
4. Arranged for the A.I.T to serve a minimum thirty-two (32) hours per week, no more than eight (8) hours daily, for each week during the internship;
5. Given personal instruction and assistance to the A.I.T and he/she has fulfilled the duties prescribed under 840 IAC 1-1-16; and
6. Met the requirements of the A.I.T program prescribed under 840 IAC 1-1-15.

Signature of preceptor

Date

I, _____, do solemnly swear or affirm under the penalties of
(Name of A.I.T)
perjury, that I have:

1. Served as an A.I.T for a minimum of six (6) months but no more than twelve (12) months, under the tutelage of _____;
2. Observed and became familiar with duties and responsibilities of my preceptor and of being an A.I.T;
3. Been assigned responsibilities in each department with experience on every shift;
4. Served as an A.I.T a minimum of thirty-two (32) hours per week, no more than eight (8) hours daily, for each week during the internship;
5. Received personal instruction and assistance from my preceptor and my preceptor has fulfilled the duties prescribed under 840 IAC 1-1-17(c); and
6. Acquired a working knowledge of health facility administration and met the requirements of the A.I.T program described in 840 IAC 1-1-15.

Signature of A.I.T

Date